

Factors that Hinder Effectiveness in the Management of the Waiver System: A case study of Kapsabet Hospital in Kenya

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Abstract

The purpose of the study was to investigate the factors that hinder effectiveness in the management of waiver system. The study used a cross-sectional design. Interview schedules, questionnaires and document review approaches were used to collect the data. Purposive sampling method was used to obtain key informant respondents from the hospital staff while simple random sampling and systematic sampling was used to obtain patient respondents. The population of this study was composed of patients at the hospital as well hospital staff involved in the management of waiver system. Data collected was analyzed using the Statistical Package for Social Sciences (SPSS). Frequency counts and percentages were used to describe the data. Among the major findings the study showed that there were no long term plans for waiver system operation and there was no inclusion of its related costs in the annual budgeting process. There was poor utilization of the waiver system among potential beneficiaries despite more than half of the patients knowing that a waiver system existed at the hospital, three waived patients per month was the norm; Age of the patient respondent was statistically significant on waiver application ($X^2 = 10.22$, $p = 0.015$). Occupation, education and income level were not significant factors in waiver application. However, Stock out of drugs, supplies, lack of information dissemination on waivers, difficulty in beneficiary identification and poor operating structure for the waiver system were some of the factors identified to hinder effectiveness in the management of the waiver system. On the basis of the findings the study recommended that there was need for the development of enforcement mechanisms for issued guidelines under the waiver system such as monitoring and evaluation of the waiver system on a prescribed timeframe and the establishment of an effective and efficient operating framework structure.

Keywords: Waiver, Undercoverage, Leakage, Effectiveness.

1.0 Introduction

During the 1990s, the donors introduced structural adjustment programmes (SAPs); these were implemented in Kenya where the government started charging a minimum fee for the delivery of the social services (health and education being the main targets) and liberalization of the provision of these services. The possibility of their implementation in the public sector was put primarily on the policy agenda following the World Bank's policy document on Financing Health Services in Developing Countries: An Agenda For Reform in 1987. This World Bank policy was reinforced by the Bamako Initiative promoted by UNICEF and endorsed by WHO and African leaders in the same year.

User fee system is a strategy where the burden of financing health care lies on the individual patient who pays for the services received, it is expected to contribute to the cost of health from their own pockets (Russel, 1996). User fee also goes by the names cost recovery, cost sharing or community financing. User fees are often one of the components of national strategies for financing health care services. Although user fees can be used to generate income from drug purchases or help fund health facilities, it can also deter people from seeking health care in a timely manner.

Most commonly, the objective of the user fee is to cover operational costs, with the revenue either applied to the service from which it is generated (to improve the service and/or to subsidize care for poor clients), or used to support the establishment of services in under served areas. However, in practice the positive benefits envisaged through user charges do not materialize or are over-shadowed by other negative unintended outcomes. The socially regressive impact of user fees in particular has been prominently highlighted in the experience of most of the developing countries.

The exhaustive reviews by (Griffin, 1987; Creese, 1991) summarizes the experiences of user fees in many Asian and African countries. Studies in different countries for the most part indicate a dampening impact of user fees on the utilization of health services. Generally it is the poor who tend to respond negatively to price increase thereby affecting equity. Fees in the health sector are thus not an instrument of health policy, but a means of fiscal policy, with the health ministry being a tax collecting agency (Creese, 1991).

However, efforts have been made to overcome some the problems associated with user fees. A study conducted in Kenya by (Collins et al, 1996) indicated that the implementation of user fees in phases according to the level of facility (national, provincial, district and sub-district hospitals and health centre) led to better acceptance both by the providers and patients. The phased implementation backed by the development of better management systems helped to reduce the decline in demand and revenue collections improved.

Over the past decade, the developing countries have struggled to maintain the provision of health services in the face of economic problems, the resurgence of poverty related sicknesses, population growth and greater public awareness on health services. World

Bank and Aid donors have recommended user fees as a mechanism for mobilizing new resource and rationalizing service delivery. This has made poor people in many developing countries not to access healthcare because they are forced to pay for services.

Governments have put in place safety nets to protect the poor and ensure a wider population has access to healthcare. However, these safety nets in form of waivers and exemptions face numerous challenges in the process of implementation. Developing an effective mechanism for defining and identifying the poor is a critical component of a successful waiver system, but it is difficult to implement as noted from various studies. A cost of recovery of Sub-Saharan African countries found that protecting the poor through waiver systems is commonly stated in policy documents. However, the definition of "the poor" is rarely clarified (Nolan et al, 1993). Another cross-country study (a survey of 26 countries) found the eligibility criteria to be vague, simply stating that fees should be waived in cases of "financial hardship" (Kenya), for those who are "destitute" (Ghana), or for the "very poor" (Uganda) (Gilson et al, 1997). In the same study, it was established that the greatest constraint to effective implementation as cited by respondents was lack of information about people's income.

A study in Ghana (Garshong et al, 2001) found out that properly identifying the poor has been a very difficult task for the health providers. They further state that, there were no clear criteria or guidelines available at any of the study sites on how to define the poor. The only quantitative finding from the study that provided demographic background information was that half who were classified as "paupers" spent less than 10,000 cedis/week (US\$ 1.37/week). Before waivers can be implemented, clear criteria to determine who the poor are should be agreed upon. Once there are clear criteria, means testing can be conducted through interviews at the health facility or an application process, involving the community or an outside social welfare agency.

In some countries in Asia such as Thailand, Cambodia and Indonesia, there have been improved measures to define or identify the poor. For example in Indonesia, the *Kartus Sehat*, or free health card program, given to poor families allow them to receive care at no charge. The card allows up to eight members of the family to be included. They must initially visit the health centre closest to them and if further treatment is needed, the *Kartus Sehat*, plus a referral letter will give them access to free health care at a public hospital (Gibbon, 1995). To identify the poor, the distribution of the *Kartus Sehat* is prioritized by the *Impres Desa Tertinggal* (IDT) villages (poor villages) predetermined by the *Biro Pusat Statistik* (BPS, Central Bureau of Statistics). All the IDT villages in the district receive the *Kartus Sehat* first, and then they are distributed to the poor in the rest of the villages (Gibbons, 1995).

Some countries have attempted to set income criteria for identifying the poor, however there is still much difficulty in verifying the income levels. Literature reviewed (Tien et al, 2002) found out that in Zambia, the income threshold for the poorest group is 15,000 Kwacha per month for an individual (US\$ 3.65). For the case of Thailand, to qualify for the

low income card, the income threshold level was 2000 Baht (US\$78.34) per month for an individual and 2800 Baht (US\$109.67) for a couple (based on 1994 exchange rates). In Zimbabwe the income ceiling that would qualify someone for a waiver was ZWD \$400/month (US\$61.43 based on 1993 exchange rate of 6.512).

Despite setting income criteria (Hecht et al, 1995) in their study in Zimbabwe document that income cannot be verified for sixty two percent (62%) of the work force who are self employed or have in-kind incomes. In Thailand too, (Gilson et al, 1998) found there were problems in using formal income criteria. While income can be one criterion, other guidelines are needed to identify the poor.

Many countries use non-income to define the poor. For example Zambia has objective criteria, such as owing debt, not having any land, or owing few assets. Kenya has more subjective criteria such as "appearance of clothes or shoes" (Tien et al, 2002). A study in Kenya (Newbrander et al, 2000) documented that a household was assessed to be poor based on the following characteristics: appearance of living quarters or home, property (land, cattle, crops, other), education level of household members, number of children enrolled in school, or clothes and shoes worn.

Systematic and sustained efforts need to be made to ensure that the policies formulated in the Ministry of Health are fully supported and implemented as documented. This is because these policies have impacts far beyond the immediate population. Challenges affecting the waiver system in public hospitals under the Ministry of Health could result to continued increase in morbidity and mortality to the general population due to negative externalities associated to ill health in the income poor population that cannot access health care. If such challenges remain unidentified, the pace of development will be slowed down, as an unhealthy population cannot be productive.

A functioning and effective waiver system is important because it enables the medically vulnerable as well as the poor members of the society to benefit from the system through correctly identifying deserving cases and in so doing improving the health status of that segment in the community. The low number of official waivers at hospitals is of great concern as it has adversely affected the vulnerable groups in their attempts to access health care in public facilities (Owino W. and Korir J., 1997). This is considering that the poor and other vulnerable groups are more prone to illhealth, seeking medical care only in exceptional cases or defer treatment until it is too late to save life.

2.0 Study Objective

- The objective of the study was to identify factors that hinder effectiveness in the management of the waiver system.

3.0 Methodology

3.1 The Design of the Study

The study design was cross-sectional aimed at describing the challenges in the management of the waiver system at Kapsabet District Hospital. The study design was chosen as the researchers intended to make a systematic analysis and description of the facts and characteristics present in the management of the waiver system. Descriptive research, according to (Best J., 1970) is concerned with conditions or relationships that exist; practices that prevail; beliefs; point of view, or attitudes that are held; processes that are going on; effects that are being felt; or trends that are developing. At times, descriptive research is concerned with how, what is or what exists is related to some preceding event that has influenced or affected a present condition or event.

3.2 Study Population

The study targeted all hospital staff involved in the management of the waiver system as well as patients present at the district hospital. The population from the hospital staff included; the District Medical Officer of Health, Hospital Matrons, Nursing Officer In-charges, Ward In-charges, In-charge of Outpatient Clinics, Social Worker and Hospital Accountant. The patient population was made up of both in-patients and out-patients.

3.3 Sample Size

All hospital departments responsible for the management of the waiver system were included in the study; these were Social Work, Nursing, Billing/Accounts, Health Administration and Outpatient departments. This is because the departments were few and including each department would greatly increase the quality of data collected while minimizing the bias that may be introduced due to sampling. Specifically hospital staff in-charge and deputies of these departments and head duty nurses in the wards were included in the study (District Medical Officer of Health (1), Hospital Matrons (8), Nursing Officer In-charge (2), Ward In-charge (5), In-charge of Outpatient Clinic (1), Clinical Officers (2), Nurses (5), Social Worker (1) and Hospital Accountant (1). All these added up to 28 respondents and were purposively selected as key informants.

Data from the hospital indicated an average out-patient number of three hundred (300) patients per day. For in-patients, average male occupancy per bed stood at 1.4 patients translating to one hundred and one (101) male patients. Female average bed occupancy stood at 2.7 patients translating to two hundred and forty three (243) patients. The total in-patient occupancy stood at three hundred and forty four (344).

To determine the sample size, the researchers decided to sample fifty percent (50%) of all the adult in-patients as well as out-patients hence the sample size of 172 respondents and 150 respondents respectively. Fifty percent (50%) was chosen as the researchers felt that half of the total patient population would be representative to collect factual data on the Challenges in the Management of the Waiver System at Kapsabet District Hospital.

3.4 Sampling Technique

A number of sampling techniques were used in this study at different level and stages. These were purposive, systematic, stratified and simple random sampling.

Purposive Sampling

Purposive sampling was used to select the study site and the key informant respondents. The study site was chosen purposively because it is the referral health facility in the district and as such as a wide catchment area. Furthermore; the district hospital is located in a district that has unique health indicators that are poorer than the neighbouring districts, the provincial average and national average. The district too, has a population of sixty four percent living below the poverty line. With these factors, the study site would deduce the challenge affecting the waiver system.

Key informants for the study were purposively selected as the researcher intended to obtain a sample that would elicit factual responses on the management of the waiver system. As key informants they are considered as individuals with special knowledge, status or communication skills as well as possessing strategic information hence have ability to provide rich information. These were approached at different times and the purpose of the study was explained. All the approached key informants participated in the study.

Stratified Sampling

The wards were first stratified as the hospital has three (3) female, two (2) male wards. Out of the five wards, four had thirty six beds each with the fifth ward (maternity) having eighteen beds. In total, female beds numbered ninety (90) while male beds numbered seventy two (72). Stratified of the wards was done to ensure that during sampling, the sample would be representative of the propositions of male and female in-patients.

Simple Random Sampling

Thirty six uniform sized pieces of papers numbered one to thirty six were put in a container and one paper was picked randomly once and replaced to represent the first bed number to be sampled in a particular ward. This procedure was repeated in each of the consecutive four wards that had thirty six beds. For the fifth ward (maternity), eighteen uniform sized pieces of papers were used and the procedure was like the other wards.

Systematic Sampling

Systematic sampling was done to get the patient respondents. For the inpatients, after getting the first bed in each ward (through simple random sampling), systematic sampling was then done to get the other subjects. Every second bed was sampled in each of the wards with all occupants in the beds being included in the study. For the male wards, thirty three (33) and thirty six (36) respondents were interviewed in the two respective wards. In the Female wards, forty (40), forty three (43) and twenty (20) respondents were interviewed in the three respective wards.

Table 1: Inpatient sample size distribution

Sex	No. of patients	No. of wards	No. of beds	Sample
Male	101	2	72	69
Female	243	3	90	103
Total	344	5	162	172

For the out patients, data was obtained on outpatient service points with daily attendance of thirty or more patients. The service points were Pharmacy, Out-patients clinic, Laboratory, Eye clinic, X-ray, Child Health clinic, Antenatal clinic and Dental. However, the child health clinic and antenatal clinic were eliminated as these clinics operated on the exemptions system and not the waiver system which was the interest of study. Every fifth patient from the start of the queue was included as a respondent. Five patients were sampled from each of these points per day for six days to get the 150 respondents.

3.5 Data Collection Methods

Data was collected by the use of a key informant interview schedule, use of a questionnaire and document review.

3.5.1 Key Informant Interview Schedule

An interview schedule was used during the personal interviews with key informants. A personal interview is a face to face interpersonal role situation in which the interviewer asks respondents questions designed to elicit answers pertinent to the research hypothesis. The researchers adopted what (Nachmias and Nachmias, 1996) refers to as "the schedule structured interview" whereby questions, their wording and sequence are fixed and identical for every interviewee. This was done to ensure that differences in responses were due to differences between respondents and not variation in the interview.

The interview schedule sought to gather data on issues such as; (1) knowledge of the waiver system; (2) functioning of the waiver system; (3) utilization of the waiver system by would be beneficiaries; (4) attitudes towards the waiver system; (5) the information about waivers provided to the facility's patients, staff and the community. The interview schedule also sought to identify the challenges affecting the waiver system. Interviews were conducted in English and Swahili and took an average of 40 minutes to administer.

3.5.2 Patient Questionnaire

The research assistants under the supervision of the researchers administered the questionnaires to the patients. The questionnaire sought to gather the patients; demographic profile; usage of the district hospital as a choice for health care; knowledge about the waiver system as well as the source of the knowledge; utilization of the waiver system.

3.5.3 Document review

Document review was used to supplement data collected through the interview and questionnaire methods. This method involved reviewing the contents of documents,

memos, minutes, intra/extra departmental correspondence of the waiver system at the hospital, the resulting data constituted the quantitative data. The researcher was looking for communication or discussion content on the management of the waiver system between and among waiver managers in the hospital, number of waivers granted and the value of such waivers. These documents were obtained upon request from the Nursing Officer In-charge at the hospital. This allowed a greater scope and depth than was possible with one primary data source, as well as providing comparison with primary data. It thus increased representativeness of data collected.

The researchers found the document review method reliable as it was possible to recheck the source of information unlike for the case of the interviews or the questionnaires. The method too, accorded the researchers an opportunity to compare and contrast responses from the interviews and questionnaires thus establishing the general functioning of the waiver system at the hospital.

3.6 Data Analysis

The collected primary data was analyzed by use of SPSS computer software. Frequency tables, Cross tabulations and Chi Square were used for analysis.

3.7 Limitation of the study

- Lack of waiver related records and correspondence at the hospital on the waiver system made review or evaluation difficult as available records were scanty, erratic and in other cases missing.

4.0 Results

4.1 Factors identified to hinder effectiveness of the waiver system

Eighteen (64.3%) of the key informants thought the waiver system was not effective compared to ten (35.7%) who thought it was effective. However, both cohorts agreed the waiver system faces numerous challenges; these were broadly tabulated as below:

Table 4.1: Factors hindering effectiveness of the waiver system

Factors hindering effectiveness of the waiver system	Frequency (n = 28)	Percentage
Leakage	2	7.1
Financing	22	78.6
Poor operating structure for the waiver system	15	53.6
Lack of information dissemination on the waiver system	12	42.9
Lack of knowledge and training on the waiver system		

Difficulty in beneficiary identification	27	96.4
Lack of incentives to the custodians of the waiver system	18	64.3
High poverty levels in the region	12	42.9
Disease burden for example HIV/AIDS		

4.2 Leakage

The interview schedule elicited possible cases of leakage due to the reliance on the applicants' word of mouth about their economic status, considering verification means were not easily available; for example, proof of income among patients presenting themselves at the facility was difficult. Some key informants said the lack of a verification mechanism on the applicant's responses could be created a loop hole for abuse of the waiver facility.

The lack of a waiver committee or panel was another reason given to possible cause leakage. Twenty five (89.29%) key informants thought a "waiver team" would easily evaluate and review case by case waiver applications. The applicants would then be interviewed by the "waiver team" to help in probing further the applicant's socio-economic status to determine eligibility. However the issue of leakage was not considered to be a major problem at the hospital.

4.3 Financing

The district hospital gets funding from the government of Kenya through the Ministry of Health as well as funds from the cost sharing programme. The revenue from these two sources has not been adequate to finance the hospital services as well as hospital supplies. Consequently, as a result of these shortages, the researchers observed that patients or their relatives were at times compelled to buy some hospital supplies such as gloves, dressings, jik and cotton wool particularly for the maternity ward.

The pharmacy at the institution lacked numerous drugs and in effect waived patients that needed drugs could not access most drugs. Drugs shortage was noted to be persistent at the institution. One key informant said one of the reasons for the drug shortage is the sourcing system. The "push" system from the Ministry of health was said to be unresponsive to the dynamic regional morbidity patterns. These observations were confirmed by more than half of the key informants.

Kapsabet District Hospital is not reimbursed for the value of services given to waived patients and the facility is expected to absorb the associated costs of waivers noted the District Medical Officer of Health. This in effect results to beneficiaries of the waiver system being composed of mainly in-patients with simple medical conditions and seldom includes patients with costly treatments. The table below (table 4.2) shows the value of waivers given over the years.

Table 4.2: Amounts waived in Kenya shillings at Kapsabet District Hospital

Year	Amount
2001	106,050.00
2002	71, 850.00
2003	182,170.00
2004	147,520.00
2005	58,050.00
Year ending October 2006	84,530.00
Totals	650,170.00

These amounts were due to the hospital for services rendered. The waiver system has no provision to seek recovery of the above amounts and this strains the already cash strapped district hospitals' resources said 22 (78.6%) of the key informants. These findings may reflect the reluctance of providers to forego significant revenue through costly waivers. Further review of the amounts waived per month had amounts as little as Kenya shillings 2,150.00 (two thousand one hundred fifty) being recorded for all patients waived in a given month.

4.4 Operating structures for the waiver system

The structure upon which the waiver system operates was pointed out as a challenge to the waiver system. For example, waiver protocols and signage in relation to the waiver managers were absent. Fifteen (53.6%) of the key informants acknowledged that the poor waiver operating structure was responsible for delay in waiver process. It was noted that it took an average of five days to process waiver applications and in effect frustrations and opportunity cost of applying for the waiver exceeded the benefits.

Some of the reasons given for the day in the waiver process included absence of the social worker from station due to home visits and patient follow ups (only one serves the whole hospital) – interestingly, the social worker has no office and is housed in the physiotherapy unit without an appropriate label on the door for identity purpose; frequent meetings in the hospital attended by signatories to the waiver process; lack of waiver forms and when present, patients have to photocopy the forms at their cost outside the hospital premises as the hospital has no working photocopier.

4.5 Information dissemination

The researchers observed no active communication by the health facility to the clients or individual patients on the existence of the waiver system and the process for obtaining the same. This, the key informants attributed to the emphasis of revenue generation at the facility; they feared abuse on the waiver system would occur if publicized. The key informants acknowledge that some poor patients who ought to be granted waivers might not be able to access health care without the knowledge. However, some key informants admitted that empathetic nurses provide waiver information to patients who upon

discharge don't leave after 4 or so days due to lack of clearing the bill; the nurses provided waiver information only when absolutely necessary.

One hundred and eighty two (58.3%) patients respondents had heard about the waiver program though majority had vague information compared to one hundred and thirty (41.7%) who had never heard of the waiver programme. The table below (table 4.3) presents the source of information in the former cohort.

Table 4.3: Source of Information about waivers

Source of Information	Frequency	Percentage
Doctor	17	9.3
Nurse	46	25.3
Social Worker	20	11
Relative	98	53.8
Other	1	53.8

The above tabulation confirms the researchers' observation about the lack of active communication to patients about the existence of a waiver facility by hospital staff.

4.6 Knowledge and training on the waiver system

The researchers wanted to know from the key informants whether they or their colleagues have received any training on the implementation of the waiver system. The researchers established that there was no current or refresher staff training to explain the policy and procedures for waivers. Out of the 28 key informants, 20 (71.43%) correctly identified the concerned officers responsible for managing the waiver system, that is, the District Medical Officer of Health, Health Administrative Officer, Nurse Officer In-charge/matron and the Social Worker.

However, only 12 (42.9%) of the key informants knew the steps involved in waiver application. It was evident that health staff who administered the system in their dealings with patients obtained knowledge about the waiver system informally from other staff members. This was reinforced by the lack of absence of staff circulars, staff meetings, inter-office memos or minutes about the waiver system from the document review. Further, the staff responsible for administering the waiver system lacked the necessary training and supplies to carry out the job.

Document review by the researchers on information about the waiver system entailed looking through the patient discharge counter books in each ward. Staff circulars, memos, minutes and inter-office correspondence on the waiver system were either absent, incomplete or erratic. Consequently, the researchers relied on counter books in each ward to extract waiver related information. A second counter book in the custody of the Nursing Officer In-charge/Matron, with a summary of waived patient's information was used to cross check data from the wards. The counter books contained data on patients'

names, amounts due, amounts waived, station (ward) treated, date waived and signature of authorizing officer. Data on ailment of waived patients was however not recorded.

The researchers found no active use of the patient waiver data and no reference was made to the records to evaluate the trends over the years or even quantify amounts waived over any period of time. Data to information transformation has not been done; no wonder the lack of knowledge about the waiver system in the institution even among the waiver managers. The lack of minutes, inter-office correspondences, letters and memos was an indicator that the waiver managers never met to evaluate the system or make any agreed decisions or recommendations.

4.7 Beneficiary identification

At Kapsabet District Hospital, the researchers observed that the waiver identification system passively waited for prospective beneficiaries to show up and request for the waivers, that is, it was demand driven. Upon an applicant requesting for a waiver, a standard form is photocopied by applicant and dully filled answering various questions about their employment, house characteristics, number and age of household members among other issues.

The researchers wanted to know the criteria in the use when granting or rejecting waivers. None was provided by any of the key informants, however, they listed attributes relating to the patients that they considered in decision making. These included: Occupation, mode of dressing/hairstyles, mode of transport to hospital, direct observation, number of dependants family size, number and type of visitors, length of stay after discharge, recommendation by social worker, and nature and type of relatives.

4.8 Incentives in waiver management

The waiver system at Kapsabet District Hospital is run and managed by hospital staff. Managers of the waiver system had their main stream duties; the institution considered these added responsibilities as a privilege to them. However, when asked about the added duties, 18 (64.3%) of the key respondents were of the opinion that a monetary compensation was lacking for the waiver managers despite the added responsibilities.

Incentives were considered by the key informants as important motivators to the achievement of tasks as well as continued desired output. These, the key informants said were absent leading to low job morale. Asked what incentives they had in mind, one key informant said incentives could take the form of costs imposed on actors – financial costs, effort, time, stigma and foregone opportunities. Other respondents said incentives may be manifested as benefits – money, promotion, recognition or power.

4.9 Disease burden

The researchers wanted to know whether disease burden was a factor in the management of the waiver system. HIV/AIDS was pointed out as a major area of concern in the hospital by 22 (78.6%) of the key informants. Bed occupancy with HIS/AIDS patients was

reported to be well above 40 percent of the total bed occupancy. With most of the HIV/AIDS patients are often abandoned by their family members and relatives especially in the tertiary stage of the illness; they then become the burden of the hospital, most crying with no compensation to the hospital for medical cost incurred during care.

A second reason given by the key informants to explain the disease burden at the hospital was increased poverty in the district. They said that poor patients are less likely to visit the district hospital on the onset of illness due to costs of treatment and associated costs such as transport and means. It is only when too ill that they come to the hospital; and this is when the waiver system and in general the hospital feels the disease burden upon itself, in the sense that, the patients now require greater health care due to the nature and extent of the illness, in effect taking longer to be discharged.

4.10 Poverty

The researchers used a combination of what (Mwabu et al, 2000) identified as determinants of poverty at the national level in Kenya to deduce an overview of the poverty indicators' present among the patients respondents. The determinants of poverty that were used in this study included: mean age, size of household, place of residence (rural or urban) and level of schooling.

The mean age of the respondents was 39 years, this age group is considered to be energetic and productive. However, 179 (70.2%) of the respondents worked in the informal sector compared to 76 (29.8%) respondents who worked in the formal sector implying most of the respondents in the informal sector were aged about 39 years. The respondents in the informal sector stated they worked as casual labourers, hawkers, farm hands, house helps and jua kali artisans among other jobs. These jobs were not only reported to be erratic but considered to have a low monetary compensation and majority were deemed to be poor in this respect.

The education level of the respondents was spread over the spectrum but majority of the respondents had only attained secondary education with a few having completed tertiary education. A large number of the respondents had only attained primary level education which was considered to be basic, and by implication it does not offer the positive opportunities associated with good education such as economic empowerment and in effect many of these respondents were deemed to be poor.

Most households were composed of 4, 5, 6 and 7 members with 37, 49, 45 and 42 respondents respectively. The modal household size was 5 members. According to the Kenya Interim Poverty Paper 2000 – 2003 large households (6.4 members) were considered to be poor unlike small households (4.6 members). Data from the study indicated most households had five members or more hence the respondents could be considered to be poor in this respect.

4.11 Level of awareness on the waiver system

One hundred and eighty two (58.3%) patient respondents were aware about the waiver system at the district hospital while 130 (41.7%) were not aware of the waiver system at the district hospital. However, in the former group, majority had scanty information about the waiver system. For example, when asked on the procedures of granting waivers, most respondents said the chiefs' letter was adequate to grant waivers at the hospital, furthermore, they did not know who was entitled to a waiver.

In the category of those that were aware of the waiver system, 45 (24.7%) were aged 18 -30 years, 62 (30.1%) were aged 31 – 43 years, 63 (34.6) were aged 44 – 56 years while 12 (6.6) were aged above 57 years. According to sex, 63 (36.6%) were male compared to 119 (65.4) females. In the category of marital status, 51 (28.0%) were single, 119 (65.4%) were married while 12 (6.6%) were widowed. Finally, in the education level category, 3 (1.7%) had received no education, 49 (27.2%) had received primary education, 71 (39.4%) had received secondary education, 48 (26.7%) had received tertiary education while 9 (5.0%) had received adult education.

Table 4.4: Gender of the respondent

Sex of the respondent		Awareness of the waiver system		Total
		Yes	No	
Male		63	58	121
	Female	119	73	192
Total		182	131	313

Table 4.5: Marital status of the respondent

Marital status		Awareness of the waiver system		Total
		Yes	No	
Single		51	49	100
	Married	119	70	189
	Widowed	12	12	24
Total		182	131	313

Table 4.6: Education level of the respondent

Education level of the respondent		Awareness of the waiver system		Total
		Yes	No	
None		3	2	5
	Primary	49	47	96
	Secondary	71	47	118
	Tertiary	48	26	74
	Other	9	6	15
Total		180	128	308

From the above cross tabulations, there is a significant association of gender, marital status and level of education with waiver awareness at 5% ($\chi^2 = 2.997$, $p = 0.083$; $\chi^2 = 4.555$, $p = 0.103$; $\chi^2 = 3.587$, $p = 0.465$ between category of respectively). More female respondents were more likely to be aware about the waiver system unlike the male respondents. Similarly more married respondents were more likely to be aware of the waiver system unlike the single respondents or the widows/widowers. Awareness of the waiver system was directly related with education level. Respondents with tertiary level of education were more likely to be aware of the waiver system unlike those with secondary or primary level education.

5.0 Conclusions and Recommendations

- Key informants (64.29%) were of the opinion that the offices and in effect the officers were not adequate to receive waiver applications, assess, investigate and grant or reject waiver applications for all the patients. They said delays in waiver processing on average lasting four days were as a result of inadequate staff to manage the waiver system considering they too had other duties to discharge. Twenty two (78.57%) of the key informants said there is need to increase the staff administering the waiver system and in particular add one or two social workers to assist in case identification, assessment and investigation. The waiver system, it was pointed out at times interferes and competes with their regular health care duties, particularly the nurses, in effect postponing or delaying the waiver process.
- Financial support to the district hospital is another factor affecting the effectiveness of the waiver system. The study established that financial support to the institution has been below budgetary requirement. The low budgetary support to the hospital resulted to the hospital administration heavily relying on the use fee for meeting non salary obligations as explained by the District Medical Officer of Health and the hospital accountant as key informants.
- Poor operating structure of the waiver system was another factor affecting the effectiveness of the waiver system. The waiver managers do not operate under an appropriate structure such as a waiver committee. Hence there was no defined structure or protocol at the district hospital for the waiver system. This was further evident in the lack of correspondence, notices or minutes of waiver related issues.
- Poverty is another factor affecting the effectiveness of the waiver system; it is a major concern of governments all over the world.
- Education is an important factor in terms of economic empowerment of individuals. It could be argued that better educated individuals can get better jobs or can be creative to do things or activities that can enable them have an income than the less educated individuals who would resort into taking up casual jobs that are poorly remunerated. However, this statement is dependent on many factors. For example, the "Ageing and Poverty Report in Kenya – Country report 2003" state that the rate of unemployment in Kenya stands close to 15 per cent of the labour force with the youth accounting for 45 percent of this

total. This high rate of unemployment has forced well educated individuals such as university graduates to resort to informal jobs such as 'hawking', being touts, drivers and related jobs considered to have a low monetary compensation.

- Out of the 182 patient respondents who were aware of the waiver system at the hospital over half of them had scanty information about it. For example, when asked on the procedures of granting waivers, most respondents said the chiefs' letter was adequate to grant waivers at the hospital, furthermore, they did not know who was entitled to a waiver.
- Lack of communication about the waiver system to patients presenting themselves at the hospital was evident from the findings of this study. The waiver system was passive and waited for patients to apply as the staff believed publicizing the waiver system would lead to abuse of it.

Based on the aforementioned conclusions, the study made the following recommendations.

- Establishing an effective operating framework structure for the waiver system through forming a working waiver committee which would then evaluate all waiver applications and recommend waivers as per defined terms of reference unlike the current situation where waiver decisions are individually made.
- Increased government funding to the district hospital to support and compensate the revenue foregone as a result of the waiver system. Success of safety nets are dependent on financing mechanism and the government through the ministry of health should review its policy on cost sharing with a view to either fully or partially compensate government public hospitals for the waivers granted.
- Publicity of the waiver system to enhance awareness among potential beneficiaries and more transparency to ensure that an increasing number of genuine cases benefit through record keeping of waivers granted, notifying the general public about the waiver system through notices at the institution and 'baraza' meetings in the villages.

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